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Original Communications.

RECOVERY FROM PNEUMOTHORAX, OCCURRING IN A CASE OF INCIPIENT PHTHISIS, WITHOUT PLEURITIC EFFUSION.

Read before the Boston Society for Medical Observation' by F. I. Knight, M.D.

Miss L. R., a lady's maid, 23 years of age, has always been delicate. Her father is said to have died after three days' sickness, "with a stitch in his side," at the age of 63. Her mother is well at the age of 60. She never had any lung trouble. They had three children; one died in infancy, one daughter is well.

Miss R. never had any long sickness. In January, 1868, she caught cold at a party; had a cough from that time until the next summer, and failed in strength. She thinks she had no cough in the fall, but sometimes had a little tightness at the top of the right chest. In September, 1868, she applied to a physician, who told her there was no disease of the lung, but gave her medicine, which caused her to spit up much thick, offensive matter, and relieved her. She never had hæmoptysis. She says she felt quite well in the beginning of the last winter, but that she got easily fatigued. She insists that she had no regular cough, but sometimes felt a kind of wheezing at the top of the right chest.

On the evening of February 8th, while walking in the street, she felt a stitch across her shoulders, and then a choking sensation and shortness of breath. She, with the aid of a companion, was able to walk home. I saw her for the first time on the afternoon of Feb. 9th. She was lying on her back, with her head raised; her face was slightly flushed; there was nothing like lividity; her countenance was somewhat anxious. When she was lying quiet the respiration was somewhat accelerated, but there was no urgent dyspnœa. The circulation was only very moderately accelerated, the pulse beating about 90 per minute. She had no cough or expectoration. Her voice was somewhat weakened. She only complained of tightness about the upper part of the sternum. Physical examination:—

On percussion there was much more resonance throughout the right chest, front and back, than in corresponding parts of the left.

On auscultation there was amphoric respiration, with amphoric whisper, and metallic tinkling synchronous with the respiration, heard over nearly the whole of the right chest.

The exaggerated resonance on percussion extended to the very base of the right chest, and there was no sound produced within the chest by succussion.

The above signs could only indicate pneumothorax. The absence of any dulness at the base, and of succussion sounds, showed that there had been no pleural effusion.

Other symptoms and signs in this case, unnecessary for the diagnosis, but which might have been interesting, were not recorded at the bedside, and hence cannot properly, according to the rules of the Society, be reported here.

Having ascertained the existence of pneumothorax, we will next, if possible, find out its cause. The various causes which may lead to the presence of air in the pleural cavity, are classified by Walsh under four heads:—

I. No Communication Existing between Pleura and External Air.—(1) Gangrene of pleura; (2) Chemical decomposition of pleural fluid; (3) Air replacing sero-purulent fluid, suddenly absorbed; (4) Secretion by pleura.

II. Communication between Pleura and Alimentary Canal.—(5) Rupture of œsophagus into pleura.

III. Communication with Atmosphere through Opening in Chest-wall.—(6) Penetrating wounds of thorax.

IV. Communication between Pleural Sac and Bronchi.

a. *Traumatic.*—(7) Tearing of lung-surface by broken ribs. (8) Violent contusion of chest, tearing lung without costal fracture.

b. *Perforation, from Disease opening the Pulmonary Pleura from within outwards, or*

centrifugal. (9) Tubercle; (10) Gangrene; (11) Diffuse pulmonary apoplexy; (12) Hydatids; (13) Cancer; (14) Emphysema; (15) Abscess; (16) Rupture in pertussis; (17) Excavated bronchial glands opening into the pleura and bronchi.

c. *Perforation from Disease opening the Pulmonary Pleura from without inwards, or Centripetal.*—(18) Empyema; (19) Parietal abscess.

We are enabled to exclude the First Class from consideration (that including the cases where no communication exists between pleura and external air), because we have evidence of such communication in the amphoric respiration heard over the right chest.

Class Second, in which there is a communication between pleura and alimentary canal, we exclude, because there are no symptoms of rupture of the œsophagus, or of previous disease, which might lead to its rupture.

Class Third is excluded, because there had been no penetrating wound of the chest.

We have now only the Fourth Class left, and of this, subdivision a. is excluded, because the patient had sustained no injury to the chest; subdivision c. is excluded, because the patient had no sign of empyema, or parietal abscess, which would cause perforation from without inwards. In subdivision b. we find (9) Tubercle, which is the cause of pulmonary perforation in the great majority of cases of this affection. Have we any evidence that our patient had so-called tubercular disease of the lung? We have no proof of it. Absolute proof of disease of the lung can only come from physical examination. I had not examined her before the development of pneumothorax, and we cannot judge accurately of the condition of the lung itself when it is surrounded by air. But she had symptoms of phthisis; she had continued cough for the first six months of last year, and lost flesh; for the rest of the year, though she says she had no regular cough, she sometimes had a little, and a tightness at the top of the right chest.

To the fact that she was told by a physician who examined her in September, that she had no disease of the lung, I do not give much weight, for the examination may not have been a careful one, and we cannot depend upon the statements of patients in regard to physicians' opinions. Although she says that she had no regular cough after summer, I suspect she had, for she had her lungs examined for some reason in September, and took cod liver oil later, I believe.

If phthisis was not the cause of the perforation, what could have been? In subdivision b. we find, besides phthisis, gangrene, diffuse pulmonary apoplexy, hydatids, cancer, emphysema, abscess, rupture in pertussis, and excavated bronchial glands opening into the pleura and bronchi, none of which we have good reason to suspect of being the cause of the perforation in this case, excepting possibly vesicular emphysema.

Gangrene and abscess require perhaps a passing notice, as she says she, after taking medicine, "spit up much thick, offensive matter." I could not elicit that the sputa had the peculiar offensiveness of gangrene, or was in such quantity as would imply the emptying of an abscess.

As she never had the symptoms of the diseases which usually precede gangrene or abscess, I think we may exclude them as a possible cause of the perforation in this case, particularly as the offensiveness and excessive amount of sputa had been long absent.

So, now, the question must be between tubercle and vesicular emphysema. I considered tubercular disease to be the cause of the perforation for the following reasons:—

1. Tubercle is a far more common cause of such perforation than is vesicular emphysema.

2. Vesicular emphysema is very rare in a person of her age, especially one with no hereditary tendencies to it.

3. Vesicular emphysema, though often more marked in one lung, or one lobe of one lung than the other, yet is a bilateral affection, showing itself to some degree on both sides.

There was no evidence of vesicular emphysema of the left lung.

4. She had *symptoms*, before the perforation, of tubercle rather than of emphysema. A cough so slight much of the time as not to attract notice, and the absence of dyspnœa, or anything like asthma, are in marked contrast to the harassing cough, and oftentimes great distress of breathing, common in emphysema.

I wish it to be understood here that I do not deny that there may have been rupture of an emphysematous vesicle, such as is found about a tuberculous deposit, but only that I consider the disease of the lung, which caused cough, &c., a year ago, and which was the ultimate cause of the perforation, to be phthisis and not emphysema.

Considering it probable that the perforation is due to "tubercular" disease, we will next consider the subject of *prognosis.*

We are generally told that the perforation of lung in a case of phthisis is very soon followed by pleurisy with effusion, the case thus becoming one of pneumo-hydrothorax. Considering it probable, then, that this case is soon to become one of pneumo-hydrothorax, what will the prognosis be? The prognosis in this affection is said to be always bad; but it is not equally so in all cases.

The points to be considered are well brought out by Dr. R. Douglas Powell, in the *Medical Times and Gazette*, Feb. 13th, 1869. He writes essentially as follows:—

"The intensity of symptoms in pneumothorax is influenced by—

A. The condition of the lung previous to its rupture.

(1.) The greater or less amount of respiratory area suddenly cut off.

(2.) The increased resistance to the flow of blood through the capillaries of the affected lung.

The greater the amount of healthy tissue left by disease, and hence suddenly collapsed, the greater the disturbance of the equilibrium, if one may use the term, between the aërating power and the blood-volume to be aërated, and hence the more urgent the dyspnœa."

"Although it was proved by Goodwyn, and more lately by Mr. Erichsen, that mere collapse of the lung does not materially affect the circulation through it, and although Mr. Erichsen's experiments tend to show that the cessation of the vital changes of respiration does not retard the circulation through the lung, yet in many cases of pneumothorax the lung is subjected to considerable pressure, and is more completely collapsed than in any of the experiments."

From some of his own experiments, he infers that "there is no appreciable difference in the resistance to the circulation through a moderately expanded lung and one collapsed by its own elasticity."

"When the lung is more completely collapsed there is a decided increase in the resistance to the circulation through it."

"The complete collapse of the lung has a very marked effect in retarding the circulation through it, independently of all external pressure."

"In this way the normal quantitative relation between the two circulations is interfered with, and death would result, but that the systemic veins admit of some, and the portal system of still greater engorgement, by which a certain amount of the surplus blood is temporarily removed from the general circulation, and time is allowed for more permanent relief, either naturally or by treatment."

"B. The state of the other lung will obviously affect the symptoms, which will be intense and fatal, *cæteris paribus*, in direct proportion to its disease."

"The nature of the opening will affect the symptoms, which will be the more urgent in proportion as the opening is more or less completely valvular.

"The temperament of the patient will influence the amount of shock."

Returning now to our patient, we are warranted in the belief that the amount of disease in the right lung previous to its rupture was slight, and that a large respiratory area was suddenly cut off.

On the other hand, the patient had in her favor the fact that the left lung was free from disease, and fortunately the opening in the pleura was perfectly free, as shown by the constant amphoric respiration.

If I had seen her at the time of the perforation, considering that she had been suddenly deprived of the use of so much lung, I should have predicted intense symptoms; but seeing her twenty-four hours after the accident so comfortable as I have described, with a non-valvular opening, I felt that no urgent symptoms need be expected until after considerable effusion, which I naturally looked for.

The condition, progress, duration, and probable termination I put thus in my own mind. She has suffered a serious accident, and has borne the shock of it much better than could have been expected. She will in all probability recover from the immediate effects of the accident, but liquid will be effused, and air and liquid will remain in the chest for an indefinite time, causing dyspnœa on exertion. It is possible for the opening to close and the air to disappear, or the air and liquid, if it should happen after effusion has taken place; but it is not probable. Finally, disease will probably attack the left lung, and thus the patient will ultimately succumb.

For treatment much less was necessary in this patient than is often required. She took quinine, beef-tea, a little wine and an occasional cathartic, and after a few days whatever food she desired.

If I had not made up my mind that there was almost no chance for the opening in the pleura to become closed, I should have in the beginning applied adhesive plaster to the affected side to prevent motion as far as possible.

Progress of the Case.—I saw the pa-

tient at first every day, and afterwards at intervals of a few days for two or three weeks. In a few days she suffered none from dyspnœa, and was able to be about the house. She complained only of weakness. She had no cough. She then moved to a distant locality. I had never found any signs of pleural effusion. The last time I saw her before her removal, the amphoric respiration was less distinct, but still evident.

April 1st.—I visited her. She experienced a very little dyspnœa on exertion, but occasionally had a feeling of tightness across the top of the chest. She had no cough in the morning; occasionally a little in the afternoon. She complained a good deal of weakness.

On examination of the chest, I found percussion normal. Respiration vesicular throughout both lungs; somewhat less intense at lower part of right lung. Vocal signs normal. On cough, very numerous fine, moist râles were heard from the right clavicle to the third rib on that side.

The perforation had evidently been closed and the air absorbed from the pleural sac, but there was evidence of phthisis at the right apex. As there is slight dulness on percussion, more bronchial element in the respiratory murmur, and more resonance of the voice in health at the right apex, compared with the left, in making a diagnosis of incipient phthisis in this region we are obliged to depend upon the signs of secondary bronchitis, viz., the moist râles, and as these were heard over a circumscribed space at the summit of the chest, we are justified, considering the symptoms previous to the perforation, in inferring the existence of phthisis.

I ordered her to lead an indolent life, to devote herself principally to eating, drinking and sleeping, to keep in the open air as much as possible, to take such exercise only as she could take without much fatigue, and to take, an hour after breakfast and an hour after tea, ℥i. cod-liver oil with whiskey.

I saw her on the 28th of April. She was then able to walk a mile without rest and without subsequent fatigue. She had no cough, but a little dyspnœa on going up stairs. She complained still of weakness and of loss of appetite. The physical signs remained as at last report. I ordered her to resume the quinine, which had been suspended several weeks before, and to continue the cod-liver oil and whiskey.

The case is interesting, because—

1. Perforation of the pleura in a case of phthisis was not followed by pleural effusion. I do not remember having seen any record of such a case.

Can we find any reason why effusion did not occur?

Effusion in these cases is considered by many to be dependent on the irritation of the pleura by liquefied tubercle rather than on the irritation of the air. Now this case was incipient and rather latent, and had not probably advanced to softening, so the pleura was not liable to irritation from this source. This seems to me the most probable reason why effusion did not occur.

2. Perforation of the pleura in a case of phthisis became closed, and the signs of pneumothorax disappeared in less than two months after the accident.

This was probably due to the fact that effusion did not occur.

3. The symptoms immediately after the perforation were quite light, when we should have expected them to have been intense, as the patient was suddenly deprived of a large respiratory area. If there had been reason to suppose very extensive disease of the right lung previous to the pleural rupture, then we should not have expected the sudden admission of air to the pleural sac to have been followed by urgent symptoms, because the system would have been previously deprived of the use of much of the lung-tissue. But in this case there was every reason to suppose that the disease was not extensive.

The key to a proper prognosis in regard to the urgency of symptoms, or the progress and termination, in cases of pneumothorax, has not yet been found, but I consider in this case that the lightness of symptoms was due, in a great measure at least, to the existence of a very free communication between the pleural sac and bronchi, so that there was mere collapse and not compression of the lung.

In this case (i. e. collapse without compression), according to the experiments of Goodwyn, Erichsen, and Powell, there would be no interference with the circulation, to which in cases of pneumothorax much of the intensity of symptoms is probably due.

4. It proves that much liquid is not necessary for the production of the physical sign known as metallic tinkling.

There was probably a little bubbling of mucus about the perforation, but not the slightest evidence of any liquid at the bottom of the pleural sac.

The treatment of this case was fortunately very simple, but as it should not

always be so, it may be well to run over here the general line of treatment which it may be proper to pursue.

1. Prevent motion in the affected side by adhesive plaster.

2. Relieve shock by opium, especially subcutaneous injections, and alcoholic stimulants. Without these we may have fatal syncope. But if the patient is strong, and seen early, bleeding may be properly resorted to. Walsh says:—"The quantity of oxygenating surface has been suddenly reduced, and the sudden disparity between that surface and the mass of the blood might, or must, I think, be somewhat lessened by diminishing the quantity of the latter. Whether this be the explanation or not, venesection does give very notable relief, and renders subsequent inflammation of the pleura less violent." Cupping, dry cupping, blisters, cannabis Indica, belladonna, stramonium, aconite and musk have also proved useful in relieving dyspnœa.

3. When there is much interference with the circulation, give hydragogue cathartics to relieve the venous congestion, and if the non-affected lung is encroached upon, and there is danger of asphyxia, puncture the chest and relieve the compression of lung.

4. Sustain the patient by a nutritious diet.

Reports of Medical Societies.

OBSTETRICAL SOCIETY OF BOSTON. SECRETARY, DAVID F. LINCOLN, M.D.

April 10th, 1869.—The Society met at the house of Dr. Putnam, at 7½, P.M., the President, Dr. Buckingham, in the chair.

Dr. Cotting reported the following case.

Mrs. —— had a good labor, her first. The milk was secreted well. On the 11th day the nurse gave—for what she thought insufficient lochial discharge, though normal in quantity—a hot injection of fennel-seed tea. The patient immediately uttered a shriek; a terrific rigor followed; and then convulsive vomiting, pains in the limbs, lasting all day, excessive rapidity and feebleness of pulse, tympanites and tenderness of the abdomen. Three dejections, with much pain. The lochial discharge remained slight. The next day, she was better; recovery speedy. "What did the injection do?"

Dr. Buckingham reported the case of a young woman, confined with her first child six weeks ago. The subsequent flow was slight, but very offensive. About four weeks after labor she was making very slow improvement; and as the offensive discharge was considered to be in part the cause of her unfavorable state, an injection was ordered—of blood-warm water, with a little salt—per vaginam. Its administration was immediately followed by a violent pain in the uterus, extending over the whole abdomen. A drachm of McMunn's elixir was given, and in three hours she fell asleep. Next day she was as well as ever, and the discharge had ceased. Two days ago he tried to give an enema to the baby, to relieve constipation. He found he could not fill the syringe; and unscrewing the instrument, discovered that one valve was gone. The nurse remarked "that it was *very hard to fill the baby*" with that syringe. It was a new instrument, and was the same which had been used for the vaginal injection of the mother. Probably air instead of water had been pumped in considerable quantity into the mother's vagina, and very likely into the uterus.

Dr. Cotting said that the instrument used in his case was a good one, and the injection of air quite improbable. He did not, however, see what greater harm would be produced by air alone than by the fluid, if injected as described.

Dr. Sinclair mentioned a case where by direction he injected with a flexible catheter a solution of tannin for menorrhagia, into a uterus which had elongated to seven inches over a mural fibrous tumor. Pain resembling that of labor instantly ensued, extending to back, abdomen and thighs. Has never since injected the uterus in similar circumstances, though he apprehends no trouble if before injection the cavity were sufficiently dilated. He stated further that air injected with a rectal enema often caused much pain; to avoid which, he cautions that the air be expelled from the syringe by completely filling it before inserting the nozzle into the rectum.

Death of the Fœtus shortly before labor, in a household attacked with well-marked Measles; the Mother remaining strong and well.—Dr. Reynolds reported the case.

Q. L., aged 34, a healthy woman, in fine bodily condition, was approaching the close of her fifth pregnancy. Three and a half weeks before labor a child seven years old had well-marked measles. Two weeks later the oldest, nine years, was attacked with the same disease. One week before delivery the fœtal movements, which had been for some days losing force, wholly ceased. The child, a large, well-developed male, was

born on the evening of the fifth instant. The mobility of the bones of the head, the condition of the epidermis, the color of the scrotum, eyelids and softer parts, and the purple and softened state of the cord, showed that death had taken place several days before birth. The placenta was throughout in a condition of fatty degeneration.

He asked whether there is, in this case, any reason to connect the death of the child with measles; whether strict care requires the removal of a child-bearing woman from the presence of an eruptive disease, even though the house should be, as in this instance, newly-roomed, well-aired and sunny.

Dr. HOOKER would advise separation, if the family lived in close quarters.

Dr. PUTNAM would regard the issue with solicitude.

Dr. SINCLAIR, in connection with the subject of fœtal auscultation, spoke of a case which came under his care while resident surgeon at the Royal Maternity Hospital, Edinburgh. A woman representing herself to be seven months advanced in pregnancy, imagined her child to have died in utero, the usual fœtal motions having been absent for two weeks. Beside himself, two experienced obstetric auscultators made several unsuccessful attempts to discover the fœtal pulsations. Two months later, however, she returned to the hospital and was delivered of a fine living child.

Dr. REYNOLDS quoted a statement by Cazeaux, that in an experience of many years, he had in no instance failed to hear the fœtal heart, when as late as the sixth month repeated examinations had been made, unless in cases where the child was subsequently shown to be dead.

Dr. BUCKINGHAM mentioned the case of a woman, near her confinement, in whom he heard a loud, distinct fœtal cardiac sound above one groin. Two students who examined her with him on different days, were unable to hear it. By another physician it was plainly heard, but on the other side, and with a difference of 15 pulsations per minute. A week later, the woman was delivered of twins.

Dr. REYNOLDS made the following remarks:—

In agreement with the teaching of Uvedale West, he believed the existence or non-existence of due flexion of the head to be the vital point in regard to cranial mal-position, not the question whether the posterior fontanelle look a little more or a little less backward. If in any case both fontanelles are within easy reach, the occipital end of the head is certainly coming down, and the position is good enough, provided no disproportion exist. Under these circumstances the occipital end of the head will come to the arch in due time, whether the turn required be three quarters of a half pelvis or only one quarter. If, on the contrary, the posterior fontanelle can only be reached with difficulty or not at all, if the great fontanelle be central, and the frontal suture be easily made out in considerable extent, the mal-position is not to be disregarded; such a case terminating in the great number of instances with the frontal end of the head at the arch, and that whether the posterior fontanelle be thought earlier in the labor to be placed obliquely forward or obliquely backward. More than this, in cases where the head is still high in the pelvis, a seeming backward direction of the posterior fontanelle is often only apparent, not real, and will disappear, or seem to come forward, if the woman be made to lie on her other side, and be then examined with the other hand of the accoucheur. (See "Cranial Position," by R. Uvedale West, in the *Glasgow Medical Journal*, parts xv. and xvi., 1856, 1857.)

Mode of applying the Forceps.—Dr. REYNOLDS thinks that in this neighborhood the usual practice is to apply the blades on the sides of the pelvis, without reference to the cranial position. All things considered, this manner of application seems to him to involve the least risk, and for inexperienced operators to be at once much easier and far safer. It is well known that not unfrequently, in oblique positions of the head, the desired rotation takes place within the blades of the forceps during extraction.

Dr. AYER mentioned a case of labor, in which he was obliged to use traction by means of the long forceps during forty minutes. The mark of the instrument, a decided bruised dent, was visible on the upper and central part of the forehead, and over the left ear. In natural presentations he thinks it safe to apply the forceps where most room is found, trusting to them to find the best position, provided we can lock them.

Dr. ARNOLD reported the birth of a child weighing 15½ pounds; labor lasting only an hour.

Dr. WELLINGTON reported a similar case, attended with rupture of the perinæum into the sphincter ani. Ordinary stitches were put in, and removed in four days, the wound doing well.

Dr. LYMAN thought that very little was gained by sutures, beyond keeping the parts from sliding over each other.

Dr. Arnold said that in several cases of rupture he had never used sutures and never seen unfavorable results.

Dr. Lyman mentioned a case that had been left without suture and had failed of union.

Dr. Hooker never used stitches but once. That case was, at least, a partial success. He never had a case of rupture followed by loss of power of the rectum or bladder, or prolapse of the vagina, or vesico-vaginal fistula.

Bibliographical Notices.

The Surgical Treatment of the Diseases of Infancy and Childhood. By T. Holmes, M.A., Cantab., late Surgeon to the Hospital for Sick Children, &c. &c. Second Edition. Philadelphia: Lindsay & Blakiston. 1869. Pp. 687.

The present issue of the above-named volume has been improved by the addition of several chapters and variously modified in accordance with the suggestions of reviewers and the reflections of the author himself. It now forms a comprehensive treatise upon a large class of affections, frequently occurring in early life, which are discussed with great erudition and in a style strongly contrasted with much that is offered in a more pretentious manner. Composed in a spirit thoroughly imbued with the importance of pathological ideas, questions of mechanical treatment and operative interference are entirely subordinated to those which involve the diagnosis and anatomy of morbid lesions; and though, from the habit and drift of the author's literary career, the various chapters are somewhat in the nature of reviews or arguments, based upon what has been said and written in different languages, they are in no sense mere compilations, but fully deserve to stand as representative of English surgery at the present day.

"Congenital affections," which take up one third of the entire volume, naturally constitute an important part of the surgery of childhood, and it would be difficult to direct the reader to a complete account, elsewhere than in this book, of many subjects included under this head, the actual status of which could otherwise be learned only by searching through medical journals, hospital reports and transactions of societies.

The complicated subject of Spina Bifida and Congenital Sacral Tumors is treated with much elaboration, and though the confusion which prevails in regard to these deformities is by no means unravelled, a large number of valuable cases and facts have been brought together. Mr. Holmes speaks of "the whole spinal cord *or* the corda equina passing through the opening" of a spina bifida (p. 79). It is an observation of Cruveilhier's that when spina bifida exists below where the cauda equina usually begins, viz., at about the second lumbar vertebra, the cord continues down in substance into the sac. This statement has been invariably confirmed in this city, and for more than twenty years commented on in his lectures by Dr. J. B. S. Jackson. It finds its explanation in the fact that the malformation has commenced at that period of embryonic life when the cord extends to the very extremity of the vertebral canal, as it normally does at a certain stage of its primitive formation.

We should be glad to have seen some reference made to an important division of this malformation into two varieties, viz., those in which the tumor is formed by fluid collected in the space between the dura mater and spinal cord (meningocele), and those in which it is formed by fluid contained in and distending the central canal of the cord itself (myelocele). In the first named variety the membranes are alone concerned; in the second the marrow itself is involved, becomes gradually distended and atrophied, until there is an actual interruption in its continuity. It is true Cruveilhier asserts that he has never seen any evidence of the fluid being contained in the substance of the spinal cord, but Virchow, in later observations, has shown the progressive steps of its distention, and in one case of spina bifida, the tumor being as large as a hen's egg, he distinctly saw the point of communication between the cyst and the cavity of the central canal (Tumors, t. i., p. 182). The distinction between a meningocele and a myelocele is therefore by no means unimportant, for in the former a favorable result may follow the evacuation of the liquid, whereas in the latter the operation can scarcely fail to be attended by grave cerebral disturbance. Mr. Holmes gives an instance in which spontaneous rupture was followed by recovery (p. 83), but he does not speak of the possibility of its occurrence during intrauterine life, the child, in rare instances, being born cured, with a puckered cicatrix, or with a red, excoriated and weeping stump, so to speak, resembling in ap-

pearance the tumors (cerebra spuria) seen outside the heads of anencephalous fœtuses, and which are the remains of hydrocephalic brains similarly ruptured before birth. It will be noticed that the two forms of spina bifida correspond to the two forms of hydrocephalus, in which the fluid is either external or internal to the ventricular cavities.

Aside from any question of treatment, there is a great difference in the symptoms presented by these two varieties of spina bifida. Myelocele, which is found in the dorsal or cervical region alone, is almost inevitably accompanied by an incurable paralysis, while a meningocele may remain during a lifetime as a local lesion of comparatively little consequence. This is especially true when the tumor is covered by integument and other soft parts, and especially if developed in the region of the sacrum. The innocuity of the affection at this point long since attracted attention, and many instances have been reported in which the subjects of such a malformation reached adult life with few if any concomitant symptoms. (See a paper by Dr. J. B. S. Jackson, on "A Peculiar Form of Spina Bifida," in Records of Boston Society for Medical Improvement, vol. iii. p. 175; also Morgagni, Virchow, Lebert.)

The singular instance of malformation occurring in the practice of the late Dr. Huntington, of Lowell, described as "a spina bifida in the form of a pendulous tumor, successfully removed," is quoted from this Journal of July 3d, 1862, but the record is thought to be so unintelligible as to justify a doubt whether it really was a case of spina bifida (p. 78). This criticism is certainly deserved; but having been induced by it to examine the preparation, which is in the Museum of the Massachusetts Medical College, we think there can be but little hesitation in pronouncing it an example of the affection in question. When presented to the College it had been in spirit three or four months, and its remarkable pedicle, alleged to have been a foot in length before the removal of the tumor, had then shrunk to the much smaller dimensions, recorded by Dr. Jackson, of two inches and a half. The deficiency in the bones of the spine at the point where the pedicle was attached, which unfortunately is not definitely stated; the characteristic absence of integument upon the tumor, and the bulging of the cicatrix left by the excision of the growth, whenever the child cried, would convince anyone who saw the specimen that it could be nothing but a spina bifida. The tumor itself consists of a single large and smoothly lined cavity, and though there are in the thickness of its parietes a few small cysts, as is not uncommon in spina bifida (Jackson, Virchow), they alone, and not the tumor, are entitled to the name of "polycystic," which Mr. Holmes applies to it. The case deserves to be relieved from the discredit it has incurred, on account of its very exceptional if not unique features. It probably belongs to that form of spina bifida, in which the neck of the sac becomes obliterated, and the latter detached from the spinal membranes, a class which is alluded to at p. 90, and the existence of which Virchow admits in his lecture on this description of tumors. The recovery of the patient after the operation of removal corroborates this view.

"Congenital sacral tumors," caused by a hernia of the spinal membranes through a deficiency in the vertebral column, or through natural orifices, and those due to fœtal inclusion, are comparatively well understood, but the "congenital cystic tumors of the sacro-coccygeal region," belonging to neither of these categories, and of which a number have been observed and safely removed by operation, are still obscure in their origin and pathology. Variously spoken of as "arachnoid cysts of the sacral region," "coccygeal tumors," "sacral hygromata," "false spina bifida," they constitute a distinct class of congenital tumors, of an extremely complex character. Ranging from simple cysts to fibroids, through all the varieties of cystic modification, and not to be confounded with fatty tumors, or the caudal excrescences of a lipomatous nature occasionally observed, they possess one feature in common, viz.:—that in whatever locality the principal portion of the growth may lie, whether within the pelvis, in the perinæum, scrotum, gluteal region or the thigh [some indeed being said to have extended down as far as the popliteal space, and even to the heel]—a more or less defined pedicle connects the tumor with the coccyx or the front of the sacrum, these bones being perfectly developed, and no communication with the meninges of the spinal cord being traceable. Since the discovery of the *coccygeal gland* the histological structure of some of these tumors, and their constant point of origin, have led to the supposition that they might be pathological modifications of this newly found body.

The coccygeal gland was discovered in 1859 by Luschka, Professor of Anatomy at Tubingen. It is situated at the anterior part of the lower extremity of the coccyx,

in the median line, between the levatores ani muscles, and lies in close relation with the ganglion impar of the great sympathetic nerve. It is of about the size of a hempseed, of a pale red color, and consists either of a single round mass, or of several aggregated granulations. The microscope shows it to be composed of glandular tissue, principally made up of round or polygonal cells, distinctly nucleated, and surrounded by exceedingly delicate granular matter, easily destroyed. It is permeated by numerous irregular tubules and culs de sac, of vascular origin, derived from a small nutrient vessel constantly found entering the gland from the sacra media artery; indeed, the disposition of vessels and their number is such that the whole structure might erroneously be considered as of vascular formation. It receives many nervous filaments from the terminal branches or the ganglion of the sympathetic. (See *Journal d'Anatomie et de Physiologie*, 1868, p. 269.)

The elementary structure of this gland has been detected in some of these congenital cystic tumors, and W. Braune (the title of whose brochure, *Die Doppelbildungen und ausgebornen Geschwülste der Kreuzbeingegend*, Leipzig, 1862, largely quoted from by Mr. Holmes, is omitted in the foot-notes), as well as MM. Perrin and Molk of Strasbourg, admit unhesitatingly a belief in their development from it. So few observations have, however, been made since this relationship was suspected, that the question is still an open one, and must remain so until the gland has been more carefully studied in the fœtus, and its alterations at the commencement of these cystic formations further examined.

There is, however, another aspect from which this inquiry gains additional interest. It is well known that the neck is a frequent seat of congenital cysts. There is in this region a little body, found near the bifurcation of the carotid artery, heretofore described as the *middle cervical ganglion* of the great sympathetic. Recent observations have given this a new character, and both Luschka and Arnold consider it a gland and not a nervous ganglion. Formed of tubules, supposed to be of vascular origin, each tube being lined with an epithelial layer and containing nucleated cells, free nuclei and granular matter, as well as many nerves and nerve cells, it presents a structure identical with that of the coccygeal gland, and is now called the *glandula intercarotica*, or *gland of Luschka*. Kölliker, in his last edition (1867) accepts these views, and they have been since confirmed by Pförtner. From this gland the compound congenital cysts of the neck are supposed to originate, and the suggestion finds confirmation in the clinical facts, well known to any one who has been unfortunate enough to meddle with them, that they are excessively vascular and of very deep origin. Further observation, especially as regards the period of intrauterine life at which these cysts form, is desirable to confirm this etiology. They have been found as early as the fourth month. (See *Gazette Hebdomadaire*, April 16, 1869, p. 264, and Boucher, *Etude sur les Kystes Congenitaux du Cou*, Paris, 1868.)

It is singular that Mr. Holmes makes no mention of these curious items in the pathological history of perineal and cervical cysts, recent discussions having made them prominent, though they may eventually prove of no importance. This is the more noticeable since, in the interval between his two editions, a comprehensive article upon these tumors has been written by Simon Duplay, in which Mr. Holmes's observations on the subject are so favorably alluded to, that the paper could scarcely have escaped his notice. It may also be observed that no description is given of those congenital dermoid cysts of the floor of the mouth, which contain sebaceous matter, churned by the action of the muscles into innumerable balls, varying in size from the head of a pin to that of a marble, according as the cyst is large or small. A very considerable number of these have been operated upon in this city, and five cases were reported by Dr. H. J. Bigelow, so long ago as 1858. They are also described by Denonviliers in the *Compendium de Chirurgie*, and by M. Paquet in the *Archives Générales*.

A peculiar case of encephalocele is cited in a foot-note to p. 63, from the Transactions of the London Pathological Society, in which a tumor protruding from the mouth was found after death to be produced by a bulging of the membranes of the brain through an orifice in the base of the skull, near the sella turcica, and to be formed of gray cerebral substance, seemingly a new growth, but not constituting an integral part of the brain. A counterpart to this may be found in the Museum of the Massachusetts Medical College, in which a perforation of the body of the sphenoid is accompanied by a tumor, which we have the authority of Dr. Jeffries Wyman for saying is the pituitary body. A similar instance, with a striking illustrative wood cut, may be found in Virchow's lectures on tumors.

Under the head of congenital malforma-

tions in the neck, closure of the œsophagus is spoken of as occurring "pretty often;" but of occlusion, with inter-communication between the œsophagus and trachea, only three cases are given. Of this malformation there are two specimens in our College Museum, and the Catalogue contains a reference to two others, observed in the practice of the late Dr. R. D. Mussey when he resided in Salem. To these we may add those of M. Tarnier, who, in a paper read before the Academy of Medicine in 1866, narrates a case of his own, and collects twelve other instances of occluded œsophagus. (*Archives Gen. de Méd.*, 1866, p. 238.)

In speaking of imperforate anus Mr. Holmes does not seem to consider a communication between the gut and the urethra in the male, or the vagina in the female, as of frequent occurrence. According to Dr. Jackson, except in monsters, and in one case where the entire large intestine was wanting, it has existed in every specimen he has examined. Several adult female subjects with this deformity have also been known to physicians in this neighborhood. The disastrous trocar punctures, not unfamiliar to surgeons here, are made the text for a condemnation of that instrument in cases of imperforation, and for the advocacy of the exploratory incision. This proving unsuccessful, or seeming unlikely to reach the intestine, Mr. Holmes advises opening the colon in front by what is known as Littre's method. "The paradox of M. Huguier," that the sigmoid flexure is to be looked for in the right iliac fossa, and not in the left, is elaborately discussed, and the conclusion arrived at, that it is immaterial in which groin the opening is made, as the colon may be reached about equally well from either direction. The chapter on imperforate anus and rectum we think is one of the most admirable in the book.

There are many points to which we should like to refer, connected with the subjects of hare lip and cleft palate, and the better success of operations which has been made possible in the latter deformity by the use of Mr. Smith's "gag," and the consequent facility of their performance under ether; with that of exstrophy of the bladder and the means available for its relief; two successful operations having been recently performed by Dr. Bigelow at the Massachusetts General Hospital; and with that of malformations of the genital organs, especially phymosis. This, though mentioned as of frequent occurrence, is not stated to be of constant and uniform existence in new-born children; another point of anatomy which we owe to Dr. Jackson's accurate observation, who has also shown that in the fœtus adhesion of the prepuce to the glans penis is invariably found. A gallant soldier, killed in the late rebellion, bore throughout his life the traces of an ineffectual attempt on the part of an eminent surgeon to rid him soon after his birth of this supposed defect.

Space hardly remains for comment on the other two divisions of the book before us, which treat of "Injuries" and "Diseases." We are happy to express our accord with the author, and respect his independence when he says:—"I am afraid that in some quarters I shall be accused of being much behind the age if I confess that I am in favor, as far as present experience goes, of the old method of tying the vessels, over the new one of securing them with needles. I have never seen any harm whatever from the use of silk ligatures in childhood, nor, in the experience I have had, any good whatever from the use of acupressure" (p. 229).

We also desire to cite Mr. Holmes as saying that tracheotomy can be best done under chloroform (p. 319), the opinion being fortified in a foot-note by a statement of Dr. Buchanan, of Glasgow, as to his favorable experience of the operation with the patient in an anæsthetic state. We have never ourselves seen any case in which its use led to a fatal result, but we are led to allude to this point of surgical practice from having seen in this JOURNAL, a short time ago, the suggestion that it might be advisable not to use ether when tracheotomy was performed for croup. Firmly convinced that the operation need not be more dangerous for being practised during etherization, we should be sorry to see parents and children debarred this priceless comfort.

Like all Englishmen, Mr. Holmes is very cautious in his denunciations of chloroform. But if half the unpleasant, and sometimes even dangerous symptoms which he speaks of as attending its inhalation (pp. 16 and 227) ever occurred with pure sulphuric ether, surgeons might be pitied indeed. As it is, our sympathies are only with the patients whose lives are unnecessarily exposed to the dangers of an anæsthetic the sole recommendation of which is its great convenience in use. A late New York journal brings us the report of two deaths in that city from chloroform, administered by the most experienced surgeons. Such events hasten the coming day of ether, but

it is to be regretted that its triumph should be attended by such a holocaust of victims.

Few surgeons have given so careful and sagacious study to the subject of Excision of Joints as Mr. Holmes. Excision of the hip he says he has performed a greater number of times than any one else, viz., in 19 instances. We give the result of these operations (p. 456) :—

"6 died from the direct effect of the operation (in one case after amputation).

1 died after the operation, from the previous effects of the disease.

1 died of independent disease, some time after recovery from amputation.

2 recovered from the operation, but not from the disease, and died a long while afterwards.

2 were little if at all benefited.

1 (twice excised) was doubtful.

3 have useful limbs, but with sinuses.

3 recovered completely."

The author evidently feels that this record requires a little special pleading, the mortality which it represents, 52·63 per cent., being, as will presently be shown, 12 per cent. greater than the latest exhibit of the death-rate of this operation in children. The most recent statistics, collated evidently with great care from all countries, are those of Dr. Good, of Paris (1869). They comprise 112 cases reported since 1860, of which 53·57 per cent. terminated fatally. Of the entire number, 59 occurred in children between 2 and 12 years of age; 40·67 per cent. of these were followed by a fatal result. But Dr. Good excludes from his table all those cases in which the cure was not verified after the operation, as well as those in which the cure was incomplete, including under this head persistent fistulous openings, even though the patient made use of the limb. Estimated with this degree of strictness, Mr. Holmes's cases (which would be reduced in number to thirteen) represent a mortality of 76·92 per cent. These figures indicate how cautiously cases should be selected, and that the indiscriminate performance of excision of the hip-joint can only bring a really valuable measure into disrepute. That increase of mortality has followed increased frequency of the operation is proved by the various tables of results collected during the past ten years. These show an advance from 36·30 per cent. (Fock, 1860) to 53·57 per cent. (Good, 1869).

It would be agreeable to quote from Mr. Holmes his sensible observations in regard to the very simple disease, necrosis, and its treatment; topics which are now so frequently obscured by new nomenclature that one hardly recognizes, beneath their disguises, old acquaintances of long before the days of Ollier and Sédillot, but the length which this notice has already reached forbids its further extension.

We have selected for reference only a few subjects from this admirable volume, and lest anything we have said should be thought inconsistent with the high praise awarded to it at the outset of our remarks, we desire to close with the expression of opinion, that it is one of the best works on surgery produced of late years, being excellent for reference, judicious in doctrine, and elegant in style of composition.

Surgical Cases. By David W. Cheever, M.D., Adjunct Professor of Clinical Surgery in Harvard University, Surgeon to the Boston City Hospital. Boston: printed for the Author. David Clapp & Son, 334 Washington St. 1869.

It is seldom that a small pamphlet of 33 pages contains the history of so many interesting and important cases as does the one recently published by Dr. Cheever.

The case of removal of an encephaloid tumor of tonsil derives peculiar interest from the circumstance that, while cancer of the tonsil is a very rare disease, and any operative interference for its relief still rarer, it is believed that this is the first instance where the tumor has been removed by external incision. The result is stated as follows :—

"In thirty-one days the wound had entirely closed. The pharynx was entirely clear; and, except that the pillars of the palate on the side affected were somewhat separated, it appeared in perfectly normal condition. The tongue was protruded in a straight line, and no paralysis of the lip remained."

This would seem to encourage surgeons to attempt its removal by external incision in other cases of this disorder, in spite of the necessary depth of the wound, and obvious dangers attending the operation.

Two cases of naso-pharyngeal polypus, requiring the performance three times of Langenbeck's operation by depression and replacement of the superior maxilla. In the first case the polypus was removed by temporary depression of the right upper maxilla. The report states that in nineteen days the ligatures had all come away; there was no purulent discharge, and the bone was in excellent position and motion-

less. After thirty-five days he was discharged well.

Disease having returned, after eleven months, operation was repeated. Convalescence in this instance was rapid, and in twenty-seven days patient was discharged, with the wounds perfectly healed, and the bone firmly in place.

In the second case "the patient was treated in a manner novel as far as we know, the operation including both superior maxillary bones." Hæmorrhage is reported as not excessive, but the shock of the operation is represented as considerable, and the succeeding symptoms as grave from that time. This patient, who is described as "feeble and anæmic from suffering and abstinence," died on the afternoon of the fifth day from the operation.

Two cases of reproduction of the tibia after excision are given. In the first there was "excision of the entire diaphysis and lower epiphysis of the tibia of a girl 13 years of age, for suppurative periostitis, followed by regeneration of the bone and a useful limb." In the second case "about five inches of the shaft were dissected out, and the extremities cut through with the chain saw. Recovery was excellent and continuous. A good limb resulted."

Eleven cases of excision of the head of the femur for "morbus coxarius" are given. "Of these, three died:—One adult, of exhaustion; one adult, of Bright's disease; one child, of tubercular meningitis. Four of these children are walking very well. The remaining four are still in bed, and under treatment."

These cases were all treated at the City Hospital, by Dr. Cheever and his colleagues. †

Uterine Catarrh frequently the Cause of Sterility—New Treatment. By H. E. Gautillon, M.D. London, New York, Savannah, Paris, Philadelphia and Baltimore.

This is a pamphlet of about 80 pages, not closely written, and divided into chapters on the Anatomy, Pathology, Causes, Symptoms, Diagnosis, Prognosis and Treatment (by the new method) of Uterine Catarrh.

The author certainly deserves credit for his proficiency in the English language; for Frenchmen usually have much difficulty with foreign languages. Although one is rather too forcibly reminded that uterine therapeutics form a *specialty* to which the author devotes himself, there is a good deal of excellent common sense in each chapter.

But a few passages need comment. We are told on page 34 that uterine catarrh is dependent on a condition of the uterus "directly opposed to anything like inflammation"; and on page 35, that "the discharge which comes from the os uteri is often mixed with blood and pus."

On page 45, under the head of diagnosis, we are told that "there is no blood in uterine catarrh."

And although we do not profess any especial knowledge of this branch of medical research, we think that the paragraph on page 49, in which a most alarming picture of the occasional consequences of uterine catarrh is given, must be received with a certain amount of reservation.

Again, we are told that the diagnosis of the affection is perfectly easy; for the *discharge* must be seen with the speculum to proceed from the os; and in order to guide us in diagnosticating cervical from uterine catarrh, we are told that, in the former, the sound does not readily pass the os internum, while in the latter case the whole muscular coat of the uterus is in a state of relaxation, which readily allows the sound to pass to the fundus.

We must be allowed to say that the chapter on diagnosis seems to us very deficient. Nothing is said about vaginal leucorrhœa, while it might properly be inferred that *uterine catarrh* was the most common of all ailments.

The "new treatment" advised consists of injections of a saturated solution of nitrate of silver, thrown up to the fundus uteri, retained there by a tampon, and repeated at intervals of from four to fifteen days or more. We are assured that no danger whatever is to be apprehended from the fluid passing into the peritoneum, and that no untoward effects ever follow this trifling operation, except in rare cases, such symptoms as "coldness of the extremities, swelling of the abdomen, smallness of the pulse, vomiting, and trembling of the limbs," "which give great alarm to inexperienced persons." We have had no experience with these injections; and would only say, that if proved harmless, they must be of benefit in many cases.

In reading the pamphlet, we think that we have noticed a similarity to some other French productions, in this respect, that the whole subject is made to appear entirely free from all difficulty, provided only that the rules of *M. Gautillon* be attended to; and we have, in particular, been reminded of a small work on "Les Amygdales," by M. Chassaignac, in which it appears that

the enlargement of these organs is of altogether more frequent occurrence than has ever been supposed; and that the most alarming train of symptoms is apt to follow, unless the "amygdales" are at once extirpated in the way prescribed, and by means of the instrument invented by *M. Chassaignac*. F. C. R.

Medical and Surgical Journal.

Boston: Thursday, July 1, 1869.

ADVERTISED MEDICINES:—THE TRAFFIC IN DRUGS. IS PHARMACY TO BECOME A SPECIALTY OF GENERAL MEDICINE?

In that portion of our work which consists in looking over the "exchanges," we are much encumbered with the extra pages which are laden with the advertisements of proprietary medicines. We have to thread our way through them in impatient search for the tables of contents. The annoyance stands next in degree to that of cutting the leaves to complete the work left unfinished by the book-binder. In selecting a medicinal preparation, a candidate for our favor would not have a better chance of being prescribed from its so getting in our way. And, we have learned to be doubly cautious about noticing in these pages any remedy that we may see blazoned in hypertrophied characters on the outside leaves of this or of any other Journal. Yet, though any practitioner of medicine who knows his business should have better ways of finding out where to get the best remedial agent than from the advertisements of interested parties, we suppose these advertisements pay, or they would not continue to be paid for.

But, what we are going to do about it? We ourselves do not direct the advertising department; and in one sense, we suppose, the publisher who gets the profit out of it may not be fully master of the situation. We encounter the grievance we complain of in handling all classes of medical periodicals—quarterly, monthly and weekly; and any publisher who should refuse to advertise proprietary medicines like his neighbors would obviously hamper his means of competing with other journals. Further, when the publishers are not medical men, it would be difficult at present fully to control their action in the matter by outside pressure. Alas, that these things are so! But, we state things as they are, and not as we would have them. We have no remedy to suggest at this moment. We cannot even say whether the disease be self-limited. We may, however, inquire what pathological condition is behind this state of things. We are, therefore, naturally led to take a glimpse at the position of the trade in drugs.

As to the wholesale drug trade, we infer that dealers can get from the importers just as good articles as they are willing to pay for; but that the tendency is, to a certain extent, to cheapen the price and the article with it. This appears from a paper on Rhubarb by Dr. E. R. Squibb before the American Pharmaceutical Association at its annual meeting in 1868. After stating that the general market for this drug had run down in quality, he goes on to say:—

Now the point desired to be made is that if pharmacists were only willing to pay such prices now, rhubarb of a quality fully equal to the Russian in medicinal value might be had, and would soon be as plentiful as ever it was. In proof of this statement the writer can offer the fact that he has never been without rhubarb which was fully equal to the Russian in his judgment, and that his price until just now has never been above $7.00, and is now $8.00, in consequence of unusual scarcity of high grades in the foreign markets. As the writer has never imported more than one package direct, and that from London, but has always gone through importing houses, the prices paid have been higher than if the market was supplied for a general demand. The last two packages received are exhibited at this meeting in connection with this note. The first of these is a chest of 130 pounds, imported to special order from Bremen, by B. W. Bull & Co., of New York. This cost 10*s*. 6*d*. sterling, which with the duty and charges make it cost here $3.75 gold or $5.50 currency. The contents of this chest were separated in two equal parts without any selection, and every lump of one-half was opened and examined. On separating the unsound and discolored pieces, which are considered unfit for medicinal uses, they are found not to exceed 20 per cent. of the

whole. This, if deducted, brings the currency cost up to $6.60, or with the labor of opening and selecting, say $6.80. This furnishes a grade of rhubarb which will be pronounced by judges as unexceptionable, and which at $8.00 per pound pays nearly 18 per cent. profit. In addition to this the 20 per cent. of rejected lumps yields by labor about 12 or 15 per cent. of its weight of sound rhubarb as good as the larger portion, only that it is in small fragments. This, when the labor of separating is charged upon it, increases the profit on the whole to over 20 per cent.

To illustrate the manner in which the market may be run down, he says :—

A distant druggist or a pharmacist wants rhubarb to supply the physicians of his neighborhood and his incidental sales, and he goes to a central market, or employs a broker there, who usually does better for him, in one sense, than he could do for himself. He finds a range of prices, which, though all low, vary very much. He looks at the root or the powder, as the case may be, and is apt to think the higher prices much too high for the slighter differences in appearance, for he rarely opens the lumps, or more than two or three of them, and the powders he must take upon faith or appearance. He never thinks of the prices being all far too low, but takes the lowest, and the merchant who has this makes the sale. A less fortunate neighbor and competitor of this merchant sees this and finds that he must buy his rhubarb lower next time. The time arrives, and he sees a lot which can be picked over, and the best of it dusted with some yellow powder will present a fair appearance, and the remainder can be made into a handsome powder by skilful millers. The price gets a shade lower and he buys. The importer of this may have sold the lot whose price successfully attracted the pharmacist, and thus made two sales where the importer of the better and unsuccessful quality only made one sale. Or, if both grades are held by the same importer he finds the lower one go off two to one. He says, "I have mistaken my market, and before these higher priced parcels are sold I must have some more of the lower, or my neighbors will get my trade away from me." His orders go out promptly with limitations which are sure to avoid the mistake for the future. And thus the common market is largely supplied, the lower grades going off rapidly, the higher grades with very slow sale and much trouble, while the highest disappear from the market, or are only heard of once in a while through some "Miss Nancy" who is rather nice than wise.

Rhubarb is a very delicate and sensitive drug, and much of it bears evidence of having been gathered immature or at a wrong season, and much of it of having been spoiled in the drying, but far more appears to get damaged in the transportation, so that it is not improbable that a very small part only of the total product ever reaches the market in a normal condition. No matter how or where it is damaged, it must be sold, and if it can be properly "doctored" there is but little of it that cannot be made to sell pretty well, either upon faith and the reputation of the seller, or upon appearance, or upon both.

Impinging closely upon the regular wholesale business is the *quondam irregular* wholesale business of the manufacturers and venders of patent or proprietary medicines. We need not dwell upon this department of the subject; but may remark, in passing, that the market is controlled, as we are informed, in respect to certain drugs by those who purchase to make them up into their proprietary pills or potions. A hundred thousand dollars invested in advertising a single preparation into popular use, and the colossal fortunes with the "palatial mansions" of some of those who have made lucky hits in dosing the public stomach, give some idea of the extent of the outside trade under consideration. It is, however, the relation of the traffic in proprietary medicines to the retail dealers in drugs—to the pharmacists—which chiefly challenges our interest here.

Some of the pharmacists of this city enjoy the confidence of the profession to an unlimited extent. Most of us would feel it sufficient praise of our proficiency as medical practitioners if we were acknowledged to be as skilful and thorough in our walk as those pharmacists are considered to be in theirs. Yet who among them will tell you they do not deal more or less in proprietary medicines? The fact is, the druggist earns but a meagre pittance, comparatively, by putting up the prescriptions of physicians. Grant him one hundred per centum profit—that gives him on a dozen pills, say, which it takes him twenty minutes to compound, and for which he

charges twenty-five cents, twelve and a half cents for his net earning. In some cases the prescription business about pays the store-rent, while clerk-hire, the principal's own living, and surplus, are gained by the sale of fancy toilet-articles and *proprietary medicines*. A druggist in a western city undertook to be an old-fashioned apothecary, depending upon the recipe business, and announced that he was about to keep himself *integer vitæ scelerisque purus* as regards patent medicines. Precisely how long he tried it we are unable to say, but we are told that at the end of a year he had as fine a stock of "proprietary medicines" as was to be found in his ilk.

But, we have not told all. It would appear that in some parts of the country the regular business of the pharmacist is becoming over-topped by the trade in proprietary medicinal articles. One of our profession—than whom there is no higher authority on this subject in the country—writes us this fact. A surgeon of his acquaintance told him that he went to many of the uptown fashionable pharmacists of New York in the vain search for three or four little round, fine sponges needed for a delicate operation; and that he must have seen during this search a display of more than one hundred thousand dollars worth of fancy goods and proprietary medicines ostentatiously exhibited. He found only two pieces of the sponge, and for these he was charged more than five times the wholesale value.

Thus far the American Pharmaceutical Association has not attempted to grapple with the evil. An admirable work it is doing in its efforts to break down the adulteration of drugs and to raise the standard of pharmacy. In these efforts it is stimulated by the influence of such men as Prof. W. Procter, Jr., the Editor of the *American Journal of Pharmacy*, and Dr. E. R. Squibb. Dr. Squibb has for more than twenty years past worked at the Materia Medica and Pharmacy as a kind of specialty. The perfection of his pharmaceutical preparations, put up in the light of chemical assay, has made them as it were classical. His zeal, however, for "the Art," and his self-abnegation in behalf of it, are not sufficiently known outside of pharmaceutical circles. We might say more. But Dr. Squibb's aversion to publicity restrains us. Notwithstanding these good influences, the American Pharmaceutical Association has not, as a body, attempted to stem the wide-spread abuse we are speaking of—perhaps because too many of its members are helplessly involved in it.*

The magnitude of the trade in proprietary medicines obviously grows out of the extensive demand for them. What are the causes of that demand? One source of it may, perhaps, be found in a false idea of economy—the patient in dread of the

* Mr. Daniel C. Robbins, however, in his Report on the Drug Market at the meeting of the American Pharmaceutical Association in 1868, says:—

On account of recent decisions in our courts of law in favor of proprietary rights in secret remedies, or patent medicines, as they are improperly called, some kind of legislation is required for public protection against this class of articles, as they have rapidly increased in number and importance, within a few years, as articles of commerce. The market list of secret proprietary preparations in use in our country far exceeds, in number of articles, that of the list of officinals in all our Materia Medica. It is generally conceded by our apothecaries that about one half of all their sales, in amount, to customers is derived from this source, and if it were possible to obtain reliable statistics of the *per capita* or total consumption of these compounds within the Union, the American people would awake, and put in chains a traffic that panders to many vices, that seldom hesitates at any imposture, and as a rule considers the deception of the public to be a legitimate business. Hair washes, called dyes or restoratives, are sold in immense quantities as purely vegetable preparations, when lead and other deleterious minerals make the substance of these. Quieting and soothing syrups are recommended and largely sold as harmless cordials or sedatives for infants, which are composed in good part of morphine, opiates or other powerful sedatives, which should never be administered without the knowledge of the parent or some competent person. The child, whose only defence consists in the power to cry, for whom resistance is a necessity for protection and for development, is drugged to sleep, growth is retarded, and the brain and nervous system permanently injured, because of the ignorance of the parent, alike of the laws of health and of the deleterious remedy, which is misrepresented in all its component parts. No restriction of any kind is imposed upon ignorant quackery, while the physician, before he can prescribe or practise medicine, must be educated and pass some examination, as also the regular apothecary, in most of the States, is obliged to label carefully, under stringent laws, all similar preparations. * * *

It is believed more secret medicinal preparations are sold and consumed in the United States than in all other countries, as throughout the continent of Europe there are very stringent regulations in regard to the sale of "nostrums."

The following is from the *New York Times*:—

A bill has been favorably reported in the Legislature, providing for the inspection of patent or *quack* medicines. The inspectors are required to ascertain their ingredients, and report the same annually to the Legislature and to the State Medical Society. There is a law analogous to this in about every country of Europe, and it doubtless often prevents the sale of deadly or injurious substances as patent medicines. The public would be startled at the exhibitions of charlatanism if the composition of some of the popular nostrums was reported.

doctor's fee sometimes paying, we take it, more for his patent medicines than the physician's advice and prescription combined would amount to. Another source, doubtless, is a notion that the medicine, with its mysterious and sounding title, the merits of which many dignitaries of the land have certified to, has in it some newly discovered drug, or owes its alleged success to some happy combination of *simples* (as in one sense is probably often the fact), of which drug or combination its manufacturers alone are cognizant. Of course we who are behind the scenes know better.

A more weighty cause, however, of the proprietary medicine harvest we find in another direction. It has been well said that the mistakes of the philosopher of one period become the vulgar errors of a succeeding generation. The physician of a former day dealt out his doses with a liberal, an unsparing hand. The practitioner of the present time, trained to demand of every remedy ample proofs of its right to be used before he will trust it, is abstemious in his employment of drugs, and leaves much to nature. It is more comfortable for him to wait for the statute of limitations to take sway, than it is for his patient who has the suffering to bear, and who becomes *im*patient. Some of the public may have understood literally the hyperbole of our genial friend in the advance guard, who said that it were better for humanity if all the drugs were thrown into the sea, only he should pity the fishes! Well, the popular mind has got by tradition from our medical predecessors the notion that when people are sick they must keep swallowing pills, powders, or draughts. If the regular Faculty will not administer them with sufficient freedom, the sick man, or his friends for him, will buy them of whomever will sell them. The Homœopathic reaction, we suspect, was not altogether against the nauseous prescriptions of former days, but grew up, in part, from this desire to be constantly "taking something" for every ailment. The pellet of sugar of milk, with triturated moonshine combined, supplied this demand, and nature had a chance to show what she could do, when neither aided nor obstructed.

But, thus far even, we believe we have told but a part of the story. The grand fact, as we think, is that whenever there is disease mankind at large have an appetency for remedies. Out of this desire (instinctive shall we say?) they cannot be reasoned, though they may be cheated by the classic charm, the transcendental mystery of the thirtieth dilution, or the Savage incantation. From Hippocrates to the Indian Medicine Man there have been those whose business it was, and is, to seek out such things as would promise to heal the aching frame.

To let our remarks, therefore, here gather to a head, a lesson we would draw from the above considerations is, that it is not for us to attempt to eradicate this universal tendency. We may prune it, we may guide it; but we must ourselves humbly follow the lead of nature. Acknowledge submissively that much that has been cherished in the past, as to supposed curative agents, has been erroneous — absurd; that the wheat has been outweighed by the chaff; that proposed remedies are now constantly being started, which have a run and then are forgotten, because tried in the balance they are found wanting. Yet, after all, it is plain to common sense, that we are in possession of some medication that is of sterling worth, while we are constantly adding to the list of drugs that assuage and ameliorate, if they do not cure; and finally, that in the very fact of the rigid analysis — the extended investigation to which every new remedy is subjected, we have the earnest that our armamentum of reliable weapons will be largely increased in the future. If we must eliminate the middle term from the *tuto, cito, et jucunde*, as applied to much of the medication that we have, or even expect soon to have at command, yet as to the remaining terms, we contend that they are applicable to considerable which we now possess; and we have reason to hope that their scope will be widely extended.

We have now glanced at the position of the wholesale drug market; at that of the pharmacist; and at the traffic in proprietary medicines. There has been another small class of extra-pharmaceutical pre-

parations which was perhaps not altogether to be reprobated. These preparations were gotten up for prescription by physicians. They *were* prescribed by physicians, and on the latter rests the chief responsibility of any impropriety connected with them. At a time when it was more difficult to get reliable drugs than it is now, certain druggists in whom the profession had confidence, offered preparations to be used by medical prescription, the nature of which compounds was disclosed; the formulæ for making them being, however, kept secret, in order to confine the sale to the manufacturer. McMunn's Elixir of Opium is in point. Its mode of preparation was not made public. But it was at one time believed to be a more reliable opiate than much of the laudanum then in the market, and it was largely prescribed by physicians. The choice being often between an article believed to be reliable—though prepared by a secret formula—on the one hand; and officinal preparations of very doubtful quality, put up by half-educated or careless apothecaries, on the other, the physician often took the first horn of the dilemma. (Would that a more flagrant complicity with the trade in secret or proprietary medicines could never be laid at the door of regular physicians!) It is our belief that the occasion for this temptation to depart from the rules of our order, however, grew out of the general neglect of pharmacy by our profession; and the emergency demanded of us as a body to initiate measures to do away with it.

The initiative, which we failed to take as a body, has been instituted by one among us, and the emergency, *for the time being*, done away with, by his single-handed efforts. The extra-pharmaceutical preparations alluded to, we think have had their day in this country. Dr. Squibb's preparations have superseded them. These are as perfect, probably, as medicines can be made, and their formulæ are published to the world. Dr. Squibb has also furnished his laboratory to place in the market a class of officinal articles of such high quality that through competition the character of the articles, as produced by others, must necessarily be raised toward what it ought to be. He stands ready, whenever another manufacturer offers a pharmaceutical article of marked excellence, to afford every encouragement to his competitor. His example has already taken root. Firms in Philadelphia, who are large manufacturers of druggists' wares, have approximated to his standard, and certain pharmacists in this city are following him very closely in the path he has marked out; while, at the same time, under the auspices of the Massachusetts College of Pharmacy, they are, with the aid of numerous lectures, diligently improving themselves in scientific knowledge, with a zeal which, if widely imitated, will tend greatly to elevate the status of the pharmacist.

Here, then, we see a great advance. And these efforts have, to a certain extent, their counterparts in our profession. Materia Medica is beginning to be investigated anew and with greater thoroughness than heretofore. But we must, perhaps, eventually go further. It may in course of time be found that *pharmacy must be made a speciality of general medicine;* and the pharmacist be a member of the medical profession, subject to its obligations and *esprit de corps*, while protected and adequately compensated. On this point we take leave to quote almost verbatim the language addressed to us by one who is, perhaps, the highest authority on this subject we have. He says the medical profession must sooner or later learn this lesson with regard to pharmacy—that it cannot be safely entrusted to the hands of mere outsiders; but that a far more accurate knowledge of materia medica and pharmacy must be attained and kept up by medical men, in order to control the specialist, and to ward off the attacks of greedy and remorseless parasites. It is only necessary to recollect the relations of pharmacy and materia medica to therapeutics; to reflect that by therapeutics, medical science and art have their only hold upon mankind as being practically useful; and that the world becomes rapidly more and more utilitarian, in order to account for the present condition of things; and also to foretell the future of legitimate medicine, if all of its best minds, and all its labors, are devoted to the Science, while the Art is

left to become a prey to ignorance and empiricism. Of what avail is it to mankind at large that the physician can diagnosticate with unerring certainty a pathological condition which he can neither remedy nor control? Will it be enough to tell people in this age of the world that the employment of common sense and judgment in regimen, and so forth, will often palliate all the most important diseased conditions, and that with such palliatives patients must try to live as long as they can? It seems to me, says our correspondent, there can be but one answer to these questions; and if so, there can be but one remedy—viz.: the accumulation of accurate knowledge in therapeutics, parallel to that of other departments of medical science. That research and investigation in this field are more laborious, and more beset by difficuities and discouragements than in some others, will in no degree mitigate the effects of neglecting them. The natural relation between labor and result is as sure in this field as in any other, and the harvest more promising.

Thus speaks one who loves the Art for its own sake.

In the *Pacific Medical and Surgical Journal* for May is a report of the "Case of Extraordinary Recovery from Extensive Saw-wound of the Skull" we mentioned in the Journal for April 29. From the report before us, which, like the former, is from Dr. A. C. Folsom, we make the following extracts, as giving some particulars in addition to the account we formerly quoted. Our selections consist of extracts from a report of Dr. A. C. Folsom; the remarks of the Editor of the *Pacific Medical and Surgical Journal*; and finally, extracts from the second statement of Dr. Folsom in reply to the editor.

The "falling apart," or "gaping open"—as it is expressed in our first quoted account—of the bones of the skull, we find it as difficult to understand as the Editor of the *Pacific Medical and Surgical Journal*.

* * * Measured by the convex surface of the skull, the length of the cut in the bones of the cranium was nine inches. They fell apart over an inch, the length of the scalp wound being eleven inches. * * *

No large arteries were severed. The pulsation of all the cerebral arteries could be distinctly seen. All that portion of the brain visible appeared normal. There was no congestion of the brain or its membranes. During the examination and dressing the pulse remained at 74. There was no pain or undue sensitiveness about the wound. The patient could not tell when the brain, its membranes, or the walls of the cut were touched, even when pressed upon with considerable force. He was sensible when the scalp-wound was touched. * * *

No medicine was ever needed during his confinement, not even an opiate. His appetite was always good and his sleep regular. There was a slight coating of the tongue the second day, but none afterward. The patient was dismissed after daily attention of three weeks, with the recommendation of perfect quiet for two or three more. * * * I have recently examined the cicatrix. The bones appear firm, with very little unnatural callus. Mental faculties perfectly intact. He says himself, that he has never suffered from headache, and never experienced any inconvenience from the injury, that he is aware of. * * *

It may not be amiss to mention, that the saw by which he was wounded is about $\frac{1}{8}$ inch thick and about 18 inches in diameter, with a speed of about 2000 revolutions per minute. The patient states that "he did not *feel* the cutting of the saw much, but heard it jingle and ring as it cut through the bones." * * *

Editorial Note [by Editor *Pacific Medical and Surgical Journal*].—Being desi to present this extraordinary and almost incredible case with all possible evidence in favor of its truth, we wrote to Dr. Folsom, requesting a more definite statement in regard to the depth of the wound and the "falling apart" of the cranial bones, with any other facts bearing on the case. We subjoin his answer in full. Our readers now have all the evidence in our possession. We may add that we have no reason for entertaining the slightest doubt with respect to the testimony, as regards the confidence to be reposed in Dr. Folsom. We had heard of the case through other channels and common report, as being extraordinary beyond belief; and this it was which induced us in the first place to write to Dr. F. for a statement of it. We do not concur in Dr. Folsom's opinion that the saw reached the base of the brain, believing this to be wholly inconsistent with the continuance of life. Had the teeth of the saw touched both extremities of the wound *at the same time*, the intervening teeth must have reached the base of the skull, dividing

the corpus callosum, optic nerve, &c. But the probability is that the saw, first striking the occiput, communicated to the head a rolling motion, drawing each succeeding portion to it, until the cut was completed. This explanation is corroborated by the statement that the scalp wound was so much longer at the occiput (two inches) than the wound in the skull. The saw, too, need not have entered the brain substance more than a few lines, for the wound seems to have been as near the falx cerebri—the membrane separating the cerebral lobes—as is consistent with the escape from injury of the longitudinal sinus, and doubtlessly the rule and the probe were both thrust between the two lobes, which, if the explanation is correct, might readily be done, even to the corpus callosum, without injury.]

MENDOCINO, March 13th, 1869.

DR. GIBBONS, Jr.

Dear Sir:—Yours of March 6th is at hand, and in answer to your inquiry I would say—the cut extended from the root of the nose to the occipital protuberance, or rather ½ an inch to the left of it, and ½ an inch below it, consequently passing through the left parietal bone, and across the coronal and lambdoidal sutures; missing, as you see, the longitudinal sinus. The widest gap in the skull was at the union of the coronal and sagittal sutures; that is, the point where measurement was taken. The wound in the scalp was longer than in the skull, at the back of the head, so I am aware there was no further fracture of the parietal bone. But fracture of the frontal bone I always suspected, for I could account for the gaping in no other way.

Why hæmorrhage was *not* fatal (in fact there was scarcely any), is because circular saws have never produced hæmorrhage to my knowledge. They strangulate the arteries. I believe the femoral could be cut by them without producing immediate death. I dare not publish it as my opinion, but I believe the saw reached the base of the skull. How could the bones fall apart otherwise? That they did fall apart I am certain, and measured the opening. I was in error as to the date of injury. It was on the 18th of August, 1864, instead of July. He was 40 years of age the following October. He is a native of Freetown, Massachusetts.

DR. HENRY J. BIGELOW sails for Europe this week, for a short visit. What with our Professors of Surgery, of Theory and Practice, and of Materia Medica, together with the Dean of the Faculty abroad, the Eastern hemisphere will this summer have, *in addition to the Alps*, a heavy weight to carry. We presume the astronomers will be on the alert for perturbations.

PERSONAL.—On Commencement Day this week, Dr. Samuel A. Green, of this city, was elected to the Board of Overseers of Harvard University, in place of Prof. Eliot, resigned.

FROM a critique on some parts of Dr. Barnes's lectures on Operative Midwifery, by Dr. E. W. Murphy, we make this extract:—

As to the space in the contracted pelvis which would authorize the Cæsarian section, Dr. Barnes fixes on 1·75″ as the length of the conjugate axis in the ovate pelvis. Dr. Osborn, who performed a successful operation of craniotomy in Elizabeth Sherwood's case, stated that the conjugate axis was an inch and a half. This success gave the opponents of the Cæsarian section great courage; but it was afterwards found that none could succeed in delivering with the perforator and crotchet in so small a space, and therefore it was inferred that either Dr. Osborn must have been wrong in his measurement, or that his case was an exception which proved the rule of the Cæsarian section. To measure the conjugate axis accurately is difficult; several instruments have been contrived for the purpose, but most of them, from Baudelocque's and Coutouly's to the most modern, have been found difficult to apply. Dr. Barnes recommends the hand to be used as the best pelvimeter, and in this he is perfectly correct; the measurement can be ascertained with much less risk of mistake, but it seems to me doubtful that, in this way, the measurement can be made to the tenth of an inch.—*London Medical Times and Gazette.*

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA AND THE COLORED DOCTORS.— * * * * The Society did not quite come up to the mark of receiving the colored doctors into social affiliation, but they have shown themselves quite as exclusive in regard to numerous white applicants in the past, and we have no doubt that the colored practitioners will, as they become better known, be able to dispel every prejudice to their social disadvantage. * * * —*Washington paper.*

Medical Miscellany.

THE N. Y. MEDICAL GAZETTE *versus* "US."—The *Gazette* compliments our "delicious coolness" because we intimated (*in re* the Doctorate of Medicine) that Massachusetts was one of the States which would require the highest standard of medical education. Why! of course we meant that New York was another of them. New England isn't too proud to have New York alongside, even now that we have had the Coliseum. Would the Editor of the *Gazette* be willing to carry his erudition to Alaska and settle there, just to astonish the natives? What a deal there is in "the way of putting things!" as the "Country Parson" has it.

Who is going to have that prize-money for ventilating sick-rooms—the *Gazette* or our correspondent "Nuss"? The old lady has got her "specs" on and is looking "sharp" for the fifty dollars to add to the Gilmore testimonial. The *Gazette* has not replied to her, but wants to do like the medical students in the dissecting room—turn the subject.

RHODE ISLAND HOSPITAL, PROVIDENCE, R. I.—We had an opportunity of visiting this institution June 24th. We found it well arranged, substantial, spacious and elegant. It is situated on an eminence commanding a view of Providence River, and receiving an abundant supply of fresh air. Only a portion of the structure has received its internal finish. There are sixty-eight beds now prepared, thirty-eight of which were occupied at the date of our visit.

The Hospital is for patients from all parts of the State; but the City of Providence as a Corporation, and by contributions from its citizens, furnished the larger portion of its cost—some three hundred and fifty thousand dollars.

HEADQUARTERS FIFTH MILITARY DISTRICT, State of Texas. Austin, Texas, May 26, 1869. General Orders, No. 104. I. The quarantine for this State, suspended by General Orders No. 24, series of 1868, Headquarters Fifth Military District, is hereby resumed; and it is made the duty of the civil and military authorities at all ports in this District, at which vessels may arrive with epidemic diseases, or from infected ports, to make and enforce, without delay, proper quarantine regulations. * * * * *

THE President to-day (June 26th) appointed William M. Wood, Surgeon in the U. S. Navy, to be Chief of the Bureau of Medicine and Surgery of the Navy Department, in the place of P. F. Horwitz, the appointment to date from July 1st.

TOOTH PULLING EXTRA.—A lady in Sarnia was recently reading to her little son that passage of Scripture quoted from the Mosaic law, "An eye for an eye, a tooth for a tooth," when the boy exclaimed, "Mamma, what a time the dentists must have had then!—*Canada Journal of Dental Science.*

THE publication of the *Provincial Medical Journal*, Halifax, N. S., ceases for the present—the Editors finding it impossible to devote to it the requisite time.

MEDICAL DIARY OF THE WEEK.

MONDAY, 9, A.M., Massachusetts General Hospital, Med. Clinic. 9, A.M., City Hospital, Ophthalmic Clinic.
TUESDAY, 9, A.M., City Hospital, Medical Clinic, 10, A.M., Surgical Lecture. 9 to 11, A.M., Boston Dispensary. 9–11, A.M., Massachusetts Eye and Ear Infirmary.
WEDNESDAY, 10, A.M., Massachusetts General Hospital, Surgical Visit. 11 A.M., OPERATIONS.
THURSDAY, 9 A.M., Massachusetts General Hospital, Medical Clinic. 10, A.M., Surgical Lecture.
FRIDAY, 9, A.M., City Hospital, Ophthalmic Clinic; 10, A.M., Surgical Visit; 11, A.M., OPERATIONS. 9 to 11, A.M., Boston Dispensary.
SATURDAY, 10, A.M., Massachusetts General Hospital Surgical Visit; 11, A.M., OPERATIONS.

TO CORRESPONDENTS.—The following communications have been received:—Medical Evidence—Niemeyer on the relation of Hæmoptysis to Phthisis—Amaurosis following Epileptiform Attack—Description of Wire Speculum. &c.

BOOKS AND PAMPHLETS RECEIVED.—Dictionnaire Annuel des Progrès des Sciences et Institutions Médicales, &c. &c., par M. P. Garnier.—Steiger's Literarischer Monatsbericht.—Transactions of the Vermont Medical Society for the years 1867 and 1868.—Secondary Degenerations of the Spinal Cord. By Ch. Bouchard. Translated from the French by Edward R. Hun, M.D.—Sixth Annual Announcement of the Charity Hospital Medical College, Cleveland, Ohio.—The Transactions of the New York Academy of Medicine, Vol. iii. Part vi. On the Etiology of Bright's Disease, &c.—Physical Culture in Amherst College. By Nathan Allen, M.D.—Roll of Students of Harvard University who served in the Army or Navy of the United States during the War of the Rebellion. Prepared, at the request of the Corporation, by Francis H. Brown, M.D.—The Relations and Reciprocal Obligations between the Medical Profession and the Educated and Cultivated Classes. An Oration delivered before the Alumni Association of the Medical Department of the University of the City of New York, Feb. 23d, 1869. By Henry S. Hewit, M.D.

CORRECTION.—In the article on Herpes Zoster Ophthalmicus, page 334, "Dr. H. F. Damon, Neuroses of the Skin, 1868," should be added to the list of monographs. B. J. J.

MARRIED,—In this city, 24th ult., Charles W. Swan, M.D., to Hetta Winchester née Karaian, both of Boston.

DIED,—In Albany, N. Y., on the 17th ult., Dr. Alden March, aged 74, Professor of Surgery in the Albany Medical College.—In Newburyport, 21st ult., Dr. Joseph Atkinson, 52 years.—In this city, 28th ult., Edward D. G. Palmer.

DEATHS IN BOSTON for the week ending Saturday noon, June 26, 83. Males, 43—Females, 40.—Accident, 4—apoplexy, 2—disease of the bladder, 1—disease of the bowels, 1—congestion of the brain, 1—disease of the brain, 4—bronchitis, 2—cancer, 3—cholera infantum, 1—consumption, 15—convulsions, 1—croup, 2—debility, 1—diarrhœa, 3—dropsy, 1—dysentery, 2—scarlet fever, 6—typhoid fever, 1—disease of the heart, 1—intemperance, 2—disease of the kidneys, 4—inflammation of the lungs, 9—marasmus, 2—cerebro-spinal meningitis, 1—old age, 1—paralysis, 1—peritonitis, 1—premature birth, 1—disease of the prostate gland, 1—puerperal disease, 2—rheumatism, 1—scrofula, 1—syphilis, 1—teething, 1—whooping cough, 2.

Under 5 years of age, 36—between 5 and 20 years, 7—between 20 and 40 years, 15—between 40 and 60 years, 8—above 60 years, 17. Born in the United States, 63—Ireland, 14—other places, 6.